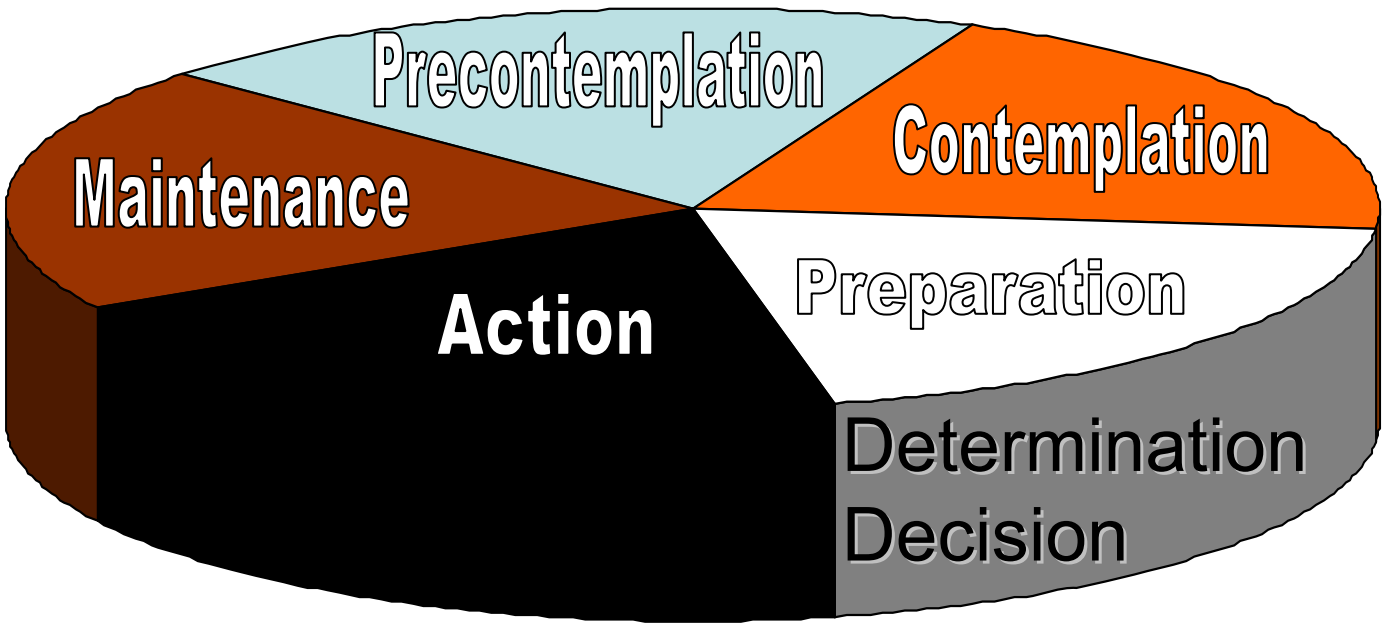
Motivational Interviewing: A Review of the Key Concepts

Objectives

- To discuss how stages of change (SOC) relates to Motivational Interviewing (MI)
- To define MI and briefly compare it to other related counseling methods
- To review the philosophy and general principals behind MI
- To present interaction techniques & counseling strategies used in MI
- To discuss potential “traps” involved in MI/counseling

Stages of Change

Prochaska & DiClemente



Stages of Change

- The goal in our counseling sessions is to try to establish where our patients are in terms of their “readiness” to change eating behaviors/habits in attempt to lose weight.

- We should be trying to move the patients from…….

From
Contemplation

To

Action

Motivational Interviewing can help move patients through the stages of change

- Motivational Interviewing (def) – a directive, client-centered counseling style for eliciting behavior change by helping clients to ***explore and resolve ambivalence***
- The examination and resolution of ambivalence is its central purpose
- The counselor is directive in pursuing this goal
- The term “Motivational” is used when the primary intent is to increase readiness for change

Key Points of the Spirit of MI

- Motivation to change is elicited from the client, and not imposed from the counselor or others
- It is the client's task alone, to articulate and resolve his/her ambivalence
- Direct persuasion is not effective for resolving ambivalence
- The counseling style is generally quiet and eliciting of information

Key Points of the Spirit of MI (cont.)

- The counselor is directive in helping the client examine and resolve ambivalence.
- Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction
- The counseling relationship is more like a partnership or companionship than expert/recipient roles

- MI should not be viewed as a technique or set of techniques applied to or “used on “ people.
- It is an interpersonal style, which is not restricted to formal counseling settings.
- It is a balance between directive and client-centered components that are influenced by understanding what triggers change.

Behaviors characteristic of a MI style

- Using reflective listening to understand a person's frame of reference.
- Expressing acceptance and affirmation.
- Reinforcing the patient's self-motivational statements of problem recognition, concern, desire, intention to change, and ability to change.
- Monitoring the patient's degree of readiness to change, and not jumping ahead of the patient
- Affirming the patient's freedom of choice and self-direction.

Differences from Other Methods

- It does not use a direct coercive approach
- It does not use direct advice giving, i.e. you do give advice, but knock on the door first to get the ok
- It does not use a confrontational approach
- It is not action-oriented
- It does not suggest the counselor totally follow the client's lead (Rogerian or Person-Centered approach)
- The focus is on resolving a patient's ambivalence about changing a behavior

Non-directional vs. MI approach

- Nondirective Approach-Allow client to determine direction of counseling
- Avoids injecting counselor's own advice & feedback
- Empathetic reflection is used noncontingently
- Explores client's conflicts & emotions as they currently exist

- Directs client toward motivation to change
- Offers counselor's advice & feedback where appropriate
- Empathetic reflection used selectively
- Seeks to create and amplify the client's discrepancy in order to enhance motivation for change.

Philosophy behind MI

- Environmental conditions usually evoke patient resistance; resistance is viewed as a reaction to the in-session behavior of the counselor
- The counselor/patient relationship should be collaborative & friendly
- MI prioritizes resolving ambivalence
  - A patient's fears and comfort level with current habits create strong ambivalent feelings about change
  - The more open the patient is about their concerns, hesitations, fears, anger, etc., the more likely there will be a collaborative relationship; the MI counselor is persuasive, not coercive; challenges the patient, but not in an argumentative way.

- The counselors educate about options available and the patient chooses the best option at the time
  - Allowing patients to pursue their own means of change increases the likelihood of long-term success, even if the goals/means chosen do not lead to immediate success.
- Patients are responsible for their progress
- MI focuses on the patient's self-efficacy

Four General Principles

- Express Empathy
  - Seeing the world through the patient's eyes.
- Support self-efficacy
  - A great way to help the patient get/stay motivated is to support his/her belief that change is possible.
- Roll with resistance
  - Statements demonstrating resistance are not challenged. Patients are encouraged to develop their own solutions → no hierarchy in client-counselor relationship.
- Develop discrepancy
  - Motivation for change occurs when patients perceive a discrepancy between where they are and where they want to be; gently identifying discrepancies between current behaviors and future goals.

MI Interaction Techniques

- OARS
  - Open ended questions
  - Affirmations
  - Reflective Listening
  - Summarization

Open-ended questions

- Cannot be answered with a “yes” “no” or “three times a week” response.
- Close-ended questions are necessary and valuable at times
- Open-ended questions allow the patients to create the impetus to move forward

Affirmations

- Statements of recognition about the patient's strengths
- Must help patients feel that change is possible
- Explore prior successful attempts at changing behavior
- Great rapport builders

Reflective listening

- The key to MI
- Listen carefully to the patients-they'll tell you what worked and what didn't work
- This has to be directive; i.e. actively guiding them toward certain areas of help.
- Focus on change talk; positive aspects of changing rather than focusing on why the person doesn't want to change
- Vary level of reflection to avoid keeping things at a surface level - going around in circles

Simple reflection-parroting

- Repeat or rephrase what the client has said-should be a statement with inflection down

Pt: *But I really have a hard time dieting. I mean, I love food and I love to eat.*

Counselor: So, changing your eating habits seems nearly impossible to you because you really enjoy your food.

Amplified reflection

- Similar to simple reflection. Counselor amplifies or exaggerates the point the client made without overdoing it. Test a hypothesis.

Pt: I can't stop eating. My wife is just too good of a cook

Counselor" So it's too hard to change your eating habits because your wife makes it difficult for you to stop eating.

Double-sided reflection

- Counselor reflects on a current, resistant statement, and a previous, contradictory statement

  Pt: *But I really have a hard time dieting. I mean, I love food and I love to eat.*

  Counselor: *So, changing your eating habits seems nearly impossible to you because you really enjoy your food, but at the same time, you are worried about the impact of your weight on your health.*

Shifting the Focus

- Shift topics to reduce resistance. Simply do not respond to resistant statements

  Pt: I just can't diet. It's too hard for me.

  Counselor: Well, let's not get too ahead of ourselves. Let's just talk about what we're doing here-talking through some of the issues relating to your weight. You can decide later if there is anything you want to do about it.

Rolling with resistance-Turn Into the Skid

- Roll with it instead of opposing it

  Pt: But I just can't lose weight. It's too hard for me.

  Counselor: And it may be very well that when we're through, you'll decide that it's not worth it to try to lose weight, that it is too hard. That will be up to you.

Reframing

- Invite patients to examine their perceptions in a new light
  - *Pt: My wife keeps yelling at me to stop eating so much junk food between meals. She's always nagging me about it.*
  - *Counselor: Your wife must care a lot about you to keep telling you this, knowing that it annoys you. She must care about your health and well being.*

- “If you are correct in your reflective statements, you may be able to deepen the intensity of your session and move forward. If incorrect, the patient corrects you and you still move ahead
- The goal in MI is to create forward momentum, and harness the momentum to create change
- Recommendation to use 3 reflections for every question asked

Summaries

- Similar to reflective listening but in summary fashion
- Recommended to do periodically throughout session, not just at the end
- Announce you are going to summarize, list selected points, invite the patient to correct anything missed, and use an open-ended question to engage the patient

Example

- “Let me just stop a minute and summarize what we’ve just talked about. You are doing some really good things to help change your diet, but you don’t see the benefit in doing anything else. You really only came here because the MD told you to come, but you do realize your weight has affected your blood sugars. Did I miss anything? What do you make of all of this?”

MI Counseling Strategies

- Reviewing a typical day
- Looking back
- Good things & less good things
- Discussing the stages of change
- Assessment feedback
- Values exploration
- Looking forward
- Exploring importance & confidence
- Decisional balance
- Change planning

- Reviewing a typical day- focus on how overeating fits into the person's life
- Looking back- what life was like prior to being overweight
- Good things/less good things- about the problem behavior or being overweight
- Discuss stages of change-explain stages and see where pt is/has been/how he got unstuck, etc.

- Assessment feedback-provide feedback to patient about his behavior
- Values exploration-focus on patient's behavioral ideals/values-helps person detect behaviors inconsistent with ideal
- Looking forward- envision 2 futures; one if they continue w/o change, the other w/change

- Explore importance & confidence- use a scale of 10 and help patient explore reasons why their numbers are not higher or lower and what it will take to get to a higher number
- Decisional balance- weigh pros and cons of changing and not changing the behaviors
- Change planning- plans within next 30 days

Change Planning

- The changes I want to make or continue to make are:
  ……..
- The reasons why I want to make these changes include:
  …….
- The steps I plan to take in changing are:
  ……..
- The ways other people can help me are to:
  ……...
- I will know that my plan is working if:
  ……
- Some things that could interfere with my plan include:
  …….
- What I will do if the plan isn't working:
  …….

- **What will I gain by changing (pros)**
  - Feel better
  - More energy
  - Able to get around better
  - Less pain

- **What will I lose by changing (cons)**
  - Social interactions
  - Feeling hungry all the time

- **What will I gain by not changing (pros)**
  - Easier, not as hard
  - Less stress

- **What will I lose by not changing (cons)**
  - I'll get heavier
  - Continue to have high B/P
  - Poor health

Reflective listening exercise

- One thing that I like about myself is that I……..

(Something abstract, not concrete like the color of your hair. Must elicit yes/no response)

- Do you mean that you …….

(closed ended-must elicit yes/no response)

Don’t Get Trapped

- Resistance (counter-motivation) may take the form of interrupting, ignoring, arguing, denying, talking about unimportant matters, daydreaming, reminiscing, etc.
- Check your current behavior, plan, expectations to make sure you haven’t moved ahead to implementation w/o checking the patient’s readiness

Question/Answer Trap

- Close-ended questions elicit passivity
- Closes off access to deeper levels of experience
- Encourages a hierarchical client-counselor relationship
- Ask open-ended questions

Confrontation/Denial Trap

- A patient provides a reasonable argument in response to every statement you make
  - e.g.
  - What do you think about trying to lose weight in order to help you lower your B/P?
  - Well, it's not so easy, I really like to eat lots of food and I don't want to have to give them all up.
  - Perhaps you might want to eat different healthier foods, rather than limiting the food you eat.
  - Yes, I've tried that but I never do it for very long. I always end up binging and then just gain weight
  - What about…..? Have you tried……?
  - Yes, but……Yes, but…….

- Encourage the patient to voice reasons for/against changing the behaviors; decisional balance. Ask the patient how important it is for him/her to change the behavior to meet what he/she listed as the pro's of changing the behavior; develop discrepancy if possible.

Expert Trap

- Counselor provides direction to the patient without helping the patient determine his/her own goals, direction, plans.
- Better to be non-directive in offering suggestions for change after exploring multiple pathways to change and upon the patient's request.

Premature Focus Trap

- Focusing too quickly on a specific problem which could lead to raising client resistance or focusing on an unimportant or secondary problem

Blaming Trap

- Patients blame others for their problems
- Counselors may try to show the patient that he/she is also at fault
- Blame is irrelevant in MI
- Establish a no-fault policy
- “Let’s not focus on who’s responsible, but rather, what’s bothering you, and what you might be able to do about it”.

Effectiveness of MI strategies

- If patients continue to argue, disagree, or ignore what you're saying, it is not working-shift methods
- If a client commits to making changes between sessions, but fails to do so upon next meeting- not necessarily a problem- it may be ambivalence.
- No shows-sign they are giving up on you, not the problem behavior-make sure you don't press too hard for change if a patient is not ready

MI in Nutshell

- Talk less than the patient/client
- Offer 2-3 reflections for each question
- Ask twice as many open-ended questions than closed questions
- Listen empathetically, using complex reflections

We Can Apply MI to help move patients through stages of change

Problems with SOC Applied to Eating Behaviors

- Eating behaviors to assist with losing weight are not discrete behaviors like substance abuse cessation; more complex
- Studies measuring SOC for eating behaviors associated with wt control used criterion measures that may not capture stage change
- Tools used to measure SOC are not always applicable to our practice

How do you feel about the following…..

	This has not crossed my mind	I should be doing this, but do not	I am ready to do this	I do this, but not regularly	I always do this
1. Avoiding junk food					X
2. Making healthier food selections when eating out				X	
3. Eating at least 5 servings of fruits and vegetables daily			X		
4. Removing tempting snack foods from your environment		X			
5. Eating only when you are hungry		X			
6. Exercising regularly 3 or more times per week					X
7. Limiting snacking in the evening				X	
8. Eating smaller portion sizes			X		
9. Writing down what you are eating daily	X				
10. Attending weekly weight loss classes	X				
11. Eating meals at regular times					X